Adam M. Cole, State Bar No. 145344
Chief Counsel, California Department of Insurance
Richard Krenz, State Bar No. 59619
Antonio A. Celaya, State Bar No. 133075
Gene S. Woo, State Bar No. 119302
Staff Counsel, California Department of Insurance
45 Fremont Street, 21st Floor
San Francisco, CA 94105
Telephone: (415) 538-4117
Facsimile: (415) 904-5490
Attorneys for Dave Jones,
Insurance Commissioner of the State of California
and the California Department of Insurance

William Bernstein, State Bar No. 065200
Robert J. Nelson, State Bar No. 132797
Nimish R. Desai, State Bar No. 244953
LIEFF, CABRASER, HEIMANN & BERNSTEIN, LLP
Embarcadero Center West
275 Battery Street, 29th Floor
San Francisco, CA 94111-3339
Telephone: (415) 956-1000
Facsimile: (415) 956-1008

William D. Hughes, State Bar No. 60370
E. Kenneth Purviance, State Bar No. 126206
HUGHES & NUNN LLP
350 10th Ave., Suite 960
San Diego, CA 92101
Telephone (619) 231-1661
Facsimile (619) 236-9271

Attorneys for Relator Rockville Recovery Associates Ltd.

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SACRAMENTO

THE STATE OF CALIFORNIA *ex rel.* ROCKVILLE RECOVERY ASSOCIATES LTD.,

Plaintiffs,

vs.

MULTIPLAN, INC. *et al.*,

Defendants.

CASE NO. 34-2010-00079432

CALIFORNIA INSURANCE COMMISSIONER'S NOTICE OF MOTION AND MOTION TO INTERVENE; MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT

Date: May 5, 2011
Time: 9:00 a.m.
Dept: 47
Judge: Hon. Steve White
Trial Date: Not Yet Set
Action Filed: February 5, 2009

TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD: YOU ARE HEREBY GIVEN NOTICE that at 9:00 a.m. on May 5, 2011, or as soon thereafter as the matter may be heard, in Department 47 of the California Superior Court, County of Sacramento, located at 720 9th Street, Sacramento, CA 95814, California Insurance Commissioner Dave Jones will and hereby does move to intervene in this action pursuant to Insurance Code section 1871.7(f)(3). The motion to intervene is based on this Notice of Motion and Motion, the accompanying California Insurance Commissioner's Complaint in Intervention, attached hereto as Exhibit A, the below Memorandum of Points and Authorities, the Declaration of Gene S. Woo, the papers and records on file in this action, any other matters of which the Court may take judicial notice, and on such additional matters as may be presented to the Court before, during or after the hearing on this motion.

Pursuant to Local Rule 2.02(D), the court will make a tentative ruling on the merits of this matter by 2:00 p.m., the court day before the hearing. To receive the tentative ruling, call the Presiding Judge's department at 874-8142. If you do not call the court and the opposing party by 4:00 p.m. the court day before the hearing, no hearing will be held.

Dated: 4-11-11

Gene S. Woo

GENE S. WOO
Senior Staff Counsel, California
Department of Insurance

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

California Insurance Commissioner Dave Jones submits this memorandum in support of his motion to intervene. Relator supports this motion.

II. BACKGROUND

Relator commenced this action in San Diego Superior Court on February 5, 2009, pursuant to the *qui tam* provisions of the California Insurance Frauds Prevention Act, Ins. Code §§1871 *et seq* ("CIFPA"). As required by that statute, the action was filed under seal, and the San Diego Superior Court entered orders extending that seal until December 31, 2009. (*Id.* § 1871.7(e)(2) & (e)(3).) On or about May 7, 2010, the San Diego Superior Court transferred the case to this Court at the Relator and Defendants' joint request.

The Relator filed a First Amended Complaint ("FAC") on June 11, 2010. Defendants filed a demurrer on July 12, 2010. On January 11, 2011, the Court denied in part and granted in part the demurrer, with leave to amend. Relator filed a Second Amended Complaint ("SAC") on January 24, 2010, and Defendants again filed a demurrer. The demurrer was heard on March 11, 2011, and denied that day. Responses to the SAC are due on April 15, 2011.

III. ARGUMENT

A. The Commissioner May Intervene Upon a Showing of Good Cause.

CIFPA creates civil liability for any violation of Penal Code § 550, which makes it unlawful to knowingly present false or fraudulent claims for payment under an insurance contract, or to submit false or misleading statements in support of a claim. The Act enables the State to "more effectively investigate and discover insurance frauds, [and] halt fraudulent activities . . . ." (Ins. Code § 1871(a).) The Legislature singled out health insurance fraud: "[A]lthough there are no precise figures, it is believed that fraudulent activities account for billions of dollars annually in added health care costs nationally. Health care fraud causes losses in premium dollars and increases health care costs unnecessarily." (*Id.* § 1871(h).)

All actions are brought in the name of the State. The Commissioner may pursue civil

actions even though the Government is not a direct victim. (*Id.* § 1871.7(d).) The State retains most of the recovery for fraud prevention, investigation and prosecution. (*Id.* § 1871.7(g)(1)(A)(iv).). CIFPA authorizes the Commissioner to initiate or intervene in a *qui tam* suit brought by a relator. (*Id.* §§ 1871.7(d), (e)(2), (f)(3).) The Commissioner may intervene without leave of court immediately following the filing of a complaint by a relator (*id.* § 1871.7(e)) or at any later time upon a showing of "good cause" (*id.* § 1871.7(f)(3)).

There is no California authority specifically interpreting "good cause" under CIFPA or analogous provisions of the California False Claims Act, Cal. Gov. Code §§ 12650 *et seq.* Federal cases interpreting similar provisions in the federal False Claims Act, 31 U.S.C. § 3730(c)(3), explain that the inquiry is a flexible one: "Good cause may include a showing of changed circumstances, the discovery of additional information, or a variety of other factors." (*United States ex rel. Roberts v. Sunrise Senior Living, Inc.* (D. Ariz. Feb. 24, 2009) 2009 U.S. Dist. LEXIS 18466, *3-4, citing *United States ex rel. Sequoia Orange Co. v. Sunland Packing* (E.D. Cal. 1995) 912 F. Supp. 1325, 1348; *United States ex rel. Stone v. Rockwell Int'l Corp.* (D. Colo. 1996) 950 F. Supp. 1046, 1049.)[1]

Under California and federal law addressing intervention generally, courts espouse a liberal policy in favor of intervention. (*Simpson Redwood Co. v. Cal.* (1987) 196 Cal. App. 3d 1192, 1200 [reversing and remanding trial court's denial of a motion to intervene as an abuse of discretion, holding that "section 387 should be liberally construed in favor of intervention"]; *cf. Kaisha v. Dodson* (N.D. Cal. 2008) 2008 U.S. Dist. LEXIS 116898, *20-21 [noting the "liberal scope of Rule 24 favoring intervention"]; *GE v. Wilkins* (E.D. Cal. 2011) 2011 U.S. Dist. LEXIS 13809, *3 ["The Ninth Circuit applies Rule 24(a) liberally, in favor of intervention..."].)

In evaluating an intervention request in a *qui tam* case, courts take into consideration the relator's view, the progress of the litigation at the time of the request, and any prejudice to defendants. (*Stone, supra,* at p. 1049 [approving intervention six years after the filing of a *qui*

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[1] *Qui tam* case law interpreting "good cause" is consistent with the California Code of Civil Procedure, which permits intervention "upon timely application, [by] any person, who has an interest in the matter in litigation, or in the success of either of the parties. . . ." (Code Civ. Proc. § 387.)

tam complaint, where the motion had the relator's support, the case was in its preliminary stages as a result of discovery delays, and there would be no prejudice to the defendant].)

In addition, information learned after the initial sealing period "could escalate the magnitude or complexity of the fraud, causing the Government to reevaluate its initial assessment or making it difficult for the *qui tam* relator to litigate alone." (S. Rep. No. 99-345, at p. 26 (1986) reprinted in 1986 U.S.C.C.A.N. 5266, 5291 [commenting on federal False Claims Act]; *accord Stone, supra,* 950 F. Supp. at 1048; *United States ex rel. Hall v. Schwartzman* (E.D.N.Y. Jan. 17, 1995) No. 93-cv-0848, 1995 U.S. Dist. LEXIS 7850, *4 [granting intervention where new information had come to light, *qui tam* plaintiffs sought assistance in prosecuting the action, and there would be no prejudice because intervention "would not result in duplicative discovery [which had recently commenced] or undue delay"]; *Roberts, supra*, 2009 U.S. Dist. LEXIS 18466, at *4 [granting unopposed intervention twenty months after the complaint was filed where Government had not completed its investigation prior to the initial deadline and additional information came to light].)

B. The Commissioner Has Good Cause to Intervene in This Case.

Good cause is established in this case on several grounds.

First, the SAC requests injunctive relief to halt Defendants' fraudulent conduct. The Commissioner has a strong interest in ensuring that appropriate injunctive relief is crafted since Defendants' conduct affects multiple California insurers, each of which is regulated by the Commissioner. The Commissioner seeks to establish injunctive remedies that will meet the broad needs of fraud prevention in California.

Second, the Commissioner has a strong interest in the development of case law under CIFPA. At present, case law interpreting CIFPA is sparse. The present case could give rise to interpretive issues under CIFPA. As the predominant bulwark against insurance fraud in California, the Commissioner seeks to participate in the development of this area of law.

Third, since unsealing, the Commissioner has investigated this case further. Based on that investigation, the Commissioner believes the allegations against Defendants are well founded and

disclose serious fraudulent conduct. The Commissioner's follow-up investigation is good cause for intervention. (See *Roberts, supra*, 2009 U.S. Dist. LEXIS 18466, at *3-4.)

Fourth, intervention will not prejudice Defendants. The case still is in the initial pleading phase. Defendants have not yet answered the SAC. Discovery remains at an early stage. On March 11, 2011, the Sutter Defendants responded to Interrogatories and Requests for Production served by the Relator in October 2010. In March 2011, Relator also served Interrogatories and Requests for Production on Defendants Multiplan and Private Healthcare Services. Those Defendants have not yet responded.

IV. CONCLUSION

The Commissioner requests that the Court enter an order granting intervention and directing the Clerk to file the accompanying Complaint in Intervention, attached hereto as Exhibit A.

Dated: 4-11-11

Dave S. Woo

GENE S. WOO
Senior Staff Counsel, California
Department of Insurance

EXHIBIT A

Adam M. Cole, State Bar No. 145344
Chief Counsel, California Department of Insurance
Richard Krenz, State Bar No. 59619
Antonio A. Celaya, State Bar No. 133075
Gene S. Woo, State Bar No. 119302
Staff Counsel, California Department of Insurance
45 Fremont Street, 21st Floor
San Francisco, CA 94105
Telephone: (415) 538-4117
Facsimile: (415) 904-5490

Attorneys for Dave Jones, Insurance Commissioner of the State of California and the California Department of Insurance

William Bernstein, State Bar No. 065200
Robert J. Nelson, State Bar No. 132797
Nimish R. Desai, State Bar No. 244953
LIEFF, CABRASER, HEIMANN & BERNSTEIN, LLP
Embarcadero Center West
275 Battery Street, 29th Floor
San Francisco, CA 94111-3339
Telephone: (415) 956-1000
Facsimile: (415) 956-1008

William D. Hughes, State Bar No. 60370
E. Kenneth Purviance, State Bar No. 126206
HUGHES & NUNN LLP
350 10th Ave., Suite 960
San Diego, CA 92101
Telephone (619) 231-1661
Facsimile (619) 236-9271

Attorneys for Relator Rockville Recovery Associates Ltd.

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SACRAMENTO

THE STATE OF CALIFORNIA, *ex rel* ROCKVILLE RECOVERY ASSOCIATES LTD.,

Plaintiffs,

v.

MULTIPLAN, INC.; PRIVATE HEALTHCARE SYSTEMS, INC.; SUTTER HEALTH; SUTTER HEALTH SACRAMENTO SIERRA REGION; EDEN MEDICAL CENTER; SUTTER EAST BAY HOSPITALS; MARIN GENERAL HOSPITAL; SUTTER COAST HOSPITAL; SUTTER WEST BAY HOSPITALS; SUTTER CENTRAL VALLEY HOSPITALS; PALO ALTO MEDICAL FOUNDATION; SUTTER GOULD MEDICAL FOUNDATION; MILLS-PENINSULA HEALTH SERVICES and DOES 1 though 500, inclusive,

Defendants.

Case No. 34-2010-00079432

CALIFORNIA INSURANCE COMMISSIONER'S COMPLAINT IN INTERVENTION [PROPOSED]

JURY TRIAL DEMANDED

Judge Alan G. Perkins
Department 35

California Insurance Commissioner Dave Jones hereby intervenes and joins with Plaintiff/Relator Rockville Recovery Associates Ltd. in this complaint.

INTRODUCTION

1. This action is based on Sutter Hospitals' routine practice of submitting false, fraudulent and/or misleading bills to insurers for supposed "anesthesia services" provided during medical procedures at their facilities, when such services were not provided, or were separately billed by the anesthesiologist or were reimbursed through other code entries on the hospitals' bills.

2. The State of California, in conjunction with *qui tam* Plaintiff Rockville Recovery Associates Ltd., brings this action under the Insurance Frauds Prevention Act, Ins. Code §§ 1871 *et seq.,* on behalf of the State of California, to recover damages, civil penalties, and injunctive relief arising from Defendants' violation of Penal Code section 550 and Insurance Code section 1871.7 through the conduct described in detail below.

INTERVENOR CALIFORNIA INSURANCE COMMISSIONER'S INTEREST IN THIS ACTION

3. The California Insurance Commissioner is the elected official chiefly responsible for insurance regulation in California. Among his duties pertinent to this action are regulation of health insurers and the investigation and prevention of insurance fraud. The Commissioner directs the Department of Insurance Fraud Division, which employs peace officers to investigate insurance fraud. Insurance fraud, including fraud of the type alleged in this complaint, affects health insurance rates.

4. The Legislature charged the Commissioner with various duties in overseeing litigation pursuant to Insurance Code section 1871.7. The Insurance Code's *qui tam* provisions anticipate that the Commissioner will have significant oversight and continuing involvement in *qui tam* cases, even after unsealing. Insurance Code section 1871.7(e)(2) requires that relators serve their sealed complaints and an explanation of their case on the Commissioner.

5. The Commissioner, as the elected public official with the primary responsibility for insurance fraud prevention, has an interest in seeing that the provisions of the

Insurance Frauds Prevention Act are fully used to remedy the harms caused by defendants' insurance fraud. The Commissioner has a further interest in pursuing the equitable relief claim in this complaint.

6. In addition to his primary interest in combating health insurance fraud, the Commissioner is interested in the development and interpretation of the provisions of the Insurance Frauds Prevention Act. By his intervention, the Commissioner seeks to participate in litigation that may assist in the development and interpretation of this statute.

JURISDICTION AND VENUE

7. This is a civil action arising under the laws of the State of California to redress violations of the California Insurance Frauds Prevention Act, Ins. Code §§ 1871.7 *et seq.*

8. This Court has jurisdiction over the subject matter of this civil claim pursuant to Cal. Ins. Code section 1871.7.

9. Venue is proper in this District because: (a) Defendants, or some of them, can be found, reside, or transact or have transacted business in Sacramento County; and (b) Defendants performed many of the relevant acts and omissions in Sacramento County.

THE PARTIES

10. Relator Rockville Recovery Associates Ltd. is a New York corporation headquartered in New York. Relator is in the business of auditing health care bills on behalf of payors, and in that capacity has developed specialized and patented software to conduct the audits. Payors that contract with Relator to perform these audits grant Relator direct access to bills submitted to the payors by various health care providers, including hospitals and physician groups that work in hospitals. Payors also grant Relator access to database compilations of submitted bills. Relator has therefore developed expertise and familiarity with the form and content of bills submitted by hospitals and physician groups.

11. From approximately 2002 to 2008, The Guardian Life Insurance Company of America hired the Relator to perform an audit of bills submitted to it. To that end, the Guardian provided Relator with direct access to claims submitted and all necessary backup, as well as large database compilations of said bills. The bills Relator reviewed included those from

numerous Sutter hospitals in California, including for example, California Pacific Medical Center. As Relator's investigation progressed, it was asked to focus on bills from Defendant Sutter Health, Inc. and its affiliated hospitals.

12. Through this investigation, and through its review of health care provider bills in unrelated investigations for other payors, Relator discovered the practice by many hospitals, including Sutter hospitals, of fraudulent billing of anesthesia services through the misuse of billing codes, as described in detail below. Faced with bills from Sutter hospitals with seemingly excessive anesthesia-related charges, Relator conducted an on-site audit at one of these hospitals, California Pacific Medical Center, in 2007. By comparing the hospital's and anesthesiologists' bills with other relevant patient records available at the hospital, Relator learned that Sutter hospitals were misusing a certain code to bill for services not provided or already compensated, as detailed below. During the on-site audit, representatives of the hospital were unable to justify or explain these charges or the basis for billing this particular revenue code on a time basis. Relator read and analyzed firsthand numerous bills by Sutter hospitals in California in which anesthesia services were fraudulently billed in this manner. Relator's investigation also indicates that Sutter hospitals bill for anesthesia services to all payors in the same allegedly fraudulent manner described below.

13. Defendant MultiPlan, Inc. ("MultiPlan") is a New York corporation headquartered in New York. MultiPlan does business in, among other places, California.

14. Defendant Private Healthcare Systems, Inc. ("PHCS") is a Delaware corporation headquartered in New York. In October 2006, PHCS was acquired by Defendant MultiPlan, and is now a subsidiary of MultiPlan.

15. Defendant Sutter Health is a California corporation headquartered in Sacramento County, California and owns, controls, and/or operates affiliated hospitals throughout California, including but not limited to each of the facilities identified in paragraphs 10-19, below.

16. Defendant Sutter Health Sacramento Sierra Region is a California corporation in the business of providing medical services, with its principal place of business in

Sacramento, California. Its sole member is Sutter Health. Defendant Sutter Health Sacramento Sierra Region operates various healthcare facilities that have engaged in misconduct described herein, including but not limited to the following:

a. Sutter Amador Hospital, located in Jackson, California.

b. Sutter Auburn Faith Hospital, located in Auburn, California.

c. Sutter Davis Hospital, located in Davis, California.

d. Sutter Medical Center of Sacramento, located in Sacramento, California, including but not limited to the following:

1. Sutter General Hospital.

2. Sutter Memorial Hospital.

e. Sutter Roseville Medical Center, located in Roseville, California.

f. Sutter Solano Medical Center, located in Vallejo, California.

17. Defendant Eden Medical Center is a California corporation in the business of providing medical services, with its principal place of business in Alameda County, California. Its sole member is Sutter Health. Defendant Eden Medical Center operates various healthcare facilities that have engaged in misconduct described herein, including but not limited to the following:

a. Eden Medical Center, located in Castro Valley, California.

b. San Leandro Hospital Campus, in San Leandro, California.

18. Defendant Sutter East Bay Hospitals is a California corporation in the business of providing medical services, with its principal place of business in Alameda County. Its sole member is Sutter Health. Defendant Sutter East Bay Hospitals operates various healthcare facilities that have engaged in the misconduct described herein, including but not limited to the following:

a. Alta Bates Summit Medical Center, located in Berkeley, California.

b. Alta Bates Summit Medical Center, Herrick Campus, located in Berkeley, California.

c. Alta Bates Medical Center, Summit Campus, located in Oakland, California.

d. Sutter Delta Medical Center, located in Antioch, California.

19. Defendant Marin General Hospital is a California corporation in the business of providing medical services, with its principal place of business in Marin County. Its sole member is Sutter Health.

20. Defendant Sutter Coast Hospital is a California corporation in the business of providing medical services, with its principal place of business in Crescent City, Del Norte County. Its sole member is Sutter Health.

21. Defendant Sutter West Bay Hospitals is a California corporation in the business of providing medical services, with its principal place of business in San Francisco County. Its sole member is Sutter Health. Sutter West Bay Hospitals operates various healthcare facilities that have engaged in misconduct described herein, including but not limited to the following:

a. California Pacific Medical Center, California Campus, located in San Francisco, California.

b. California Pacific Medical Center, Davies Campus, located in San Francisco, California.

c. California Pacific Medical Center, Pacific Campus, located in San Francisco, California.

d. California Pacific Medical Center, St. Luke's Campus, located in San Francisco, California.

e. Novato Community Hospital, located in Novato, California.

f. Sutter Lakeside Hospital and Center for Health, located in Lakeport, California.

g. Sutter Medical Center of Santa Rosa, located in Santa Rosa, California, including but not limited to the following:

1. Sutter Medical Center of Santa Rosa;

2. Sutter Medical Center of Santa Rosa, Warrack Campus.

22. Defendant Sutter Central Valley Hospitals is a California corporation in the business of providing medical services, with its principal place of business in Stanislaus County. Its sole member is Sutter Health. Defendant Sutter Central Valley Hospitals operates various healthcare facilities that have engaged in misconduct described herein, including but not limited to the following:

a. Memorial Medical Center, located in Modesto, California.

b. Memorial Hospital Los Banos, located in Los Banos.

c. Sutter Tracy Community Hospital, located in Tracy, California.

23. Defendant Palo Alto Medical Foundation, is a California corporation, in the business of providing medical services, with its principal place of business in Mountain View, California. It is affiliated with Sutter Health. Defendant Palo Alto Medical Foundation operates various healthcare facilities that have engaged in misconduct described herein, including but not limited to the following:

a. Menlo Park Surgical Hospital, located in Menlo Park, California.

b. Sutter Maternity & Surgery Center of Santa Cruz, California.

c. Surgical Offices, including but not limited to the following:

1. Freemont Center, in Fremont, California.

2. Palo Alto Center, in Palo Alto, California.

3. Mountain View Center, in Mountain View, California.

4. Redwood City Center, in Redwood City, California.

5. Chanticleer Office (2900), located in Santa Cruz, California.

6. Chanticleer Office (2911), located in Santa Cruz, California.

7. Dominican Way Office, located in Santa Cruz, California.

8. Research Park Office, located in Soquel, California.

24. Defendant Sutter Gould Medical Foundation is a California corporation, in the business of providing medical services, with its principal place of business in Modesto, California. It is affiliated with Sutter Heath. Defendant Sutter Gould Medical Foundation operates

various healthcare facilities that have engaged in misconduct described herein, including but not limited to the following:

a. Stockton Medical Plaza, located in Stockton, California.

b. Stockton Surgery Center, located in Stockton, California.

c. Briggsmore Specialty Clinic, located in Modesto, California.

25. Defendant Mills-Peninsula Health Services is a California corporation, in the business of providing medical services, with its principal place of business in Burlingame, California. It is affiliated with Sutter Health. Defendant Mills-Peninsula Health Services operates various healthcare facilities that have engaged in misconduct described herein, including but not limited to the following:

a. Peninsula Medical Center, located in Burlingame, California.

b. Mills Health Center, located in San Mateo, California.

26. Defendants Sutter Health, Sutter Health Sacramento Sierra Region, Eden Medical Center, Sutter East Bay Hospitals, Marin General Hospital, Sutter Coast Hospital, Sutter West Bay Hospitals, Sutter Central Valley Hospitals, Palo Alto Medical Foundation, Sutter Gould Medical Foundation, and Mills-Peninsula Health Services are sometimes hereafter referred to collectively as the "Sutter Defendants".

27. The true names or capacities, whether individual, corporate, associate or otherwise of defendants DOES 1 through 500 are unknown to Plaintiffs, who therefore sue such defendants by such fictitious names. Plaintiffs are informed and believe and thereon allege that each of the defendants designated herein as a DOE is legally responsible in some manner for the events and happenings herein referenced.

28. DOES 1 through 100 are medical corporations or similar entities which operate healthcare facilities and are under contract with MultiPlan or PHCS with terms substantially similar to those with Sutter Health and the Sutter Affiliates.

29. DOES 101 through 400 are medical corporations or similar entities located in the state of California which operate healthcare facilities and are under contract with DOES

401 through 500, or any of them, with contractual terms and agreements that are substantially similar to those Sutter Health and the Sutter Affiliates have with MultiPlan.

30. DOES 401 through 500 are corporations or similar entities which act as third party administrators (i.e. such as Health Maintenance Organizations ("HMOs") or Preferred Provider Organizations ("PPOs")) similar to Defendants MultiPlan and PHCS with business plans that are substantially similar to those Defendants (as described more fully below).

31. On information and belief, each Defendant was the agent, joint venturer and/or employee of each of the remaining Defendants, and in acting as described herein, each Defendant was acting within the scope of said agency, employment and/or joint venture, with the advance knowledge, acquiescence or subsequent ratification of each and every remaining Defendant.

FACTUAL ALLEGATIONS

32. This action is brought pursuant to Penal Code section 550 and Insurance Code section 1871.7. Penal Code section 550 criminalizes the act of knowingly presenting false, fraudulent or misleading claims to an insurance company.

33. In order to combat rampant insurance fraud, in 1993, the California Legislature enacted the Insurance Frauds Prevention Act ("CIFPA" or "the Act"), codified at Insurance Code section 1871, *et seq.*

34. The Legislature recognized the "potential for abuse and illegal activities" and designed the CIFPA "to permit the full utilization of the expertise of the commissioner and the department so that they may more effectively investigate and discover insurance frauds, [and] halt fraudulent activities." (Ins. Code 1871(a).)

35. The Legislature also highlighted the negative impact of health insurance fraud in particular, advising that it is believed that fraudulent activities account for billions of dollars annually in added health care costs nationally. Health care fraud causes losses in premium dollars and increases health care costs unnecessarily." (Ins. Code § 1871(h).)

36. To combat this fraud, the Act permits civil enforcement of relevant provisions of the Penal Code, either by the State or by any "interested person" on behalf of the

State, *i.e.*, a relator in a *qui tam* action. Specifically, section 1871.7 provides that any person who violates Penal Code sections 549, 550, or 551, is liable for civil penalties between $5,000 and $10,000, plus an assessment of not more than three times the amount of each claim for compensation, as defined in Section 3207 of the Labor Code or pursuant to the contract of insurance.

37. The Act allows any person having knowledge of illegal conduct as specified in Insurance Code Section 1871.7 to bring an action and to share in any recovery. Pursuant to section 1871.7(e)(2), the complaint is to be filed under seal for 60 days (without service on the Defendants) to enable the State or county government to: (1) conduct its own investigation without the knowledge of the Defendants; and (2) determine whether to join the suit. The Relator must also file with the applicable County District Attorney, and the Insurance Commissioner, the complaint and a detailed statement disclosing all material evidence and information in the Relator's possession.

38. Relator has complied with the requirements of Insurance Code section 1871.7(e)(2).

39. The facts in support of this action were developed through Relator's direct and personal knowledge, derived through a review of actual bills submitted by Sutter hospitals. Relator is the original source for all of the information contained in this complaint. This lawsuit is not based on any public disclosure of the allegations or transactions which form the basis of this lawsuit.

40. The State seeks to recover damages and civil penalties arising from Defendants' violation of Insurance Code section 1871.7 and Penal Code section 550. Specifically, Defendants conspired to prepare, and did prepare false, fraudulent, and misleading records and bills, and submitted or caused to be submitted said records and bills in support of fraudulent insurance claims to insurance companies and/or third party administrators such HMOs and PPOs for their review and submission to insurance companies. The fraudulent records and bills were created to pursue fraudulent insurance claims, thereby violating Penal Code section 550(a) and (b).

Overview of Billing for Anesthesia Services

41. Anesthesia involves the use of medicines to block pain sensations during surgery and other medical procedures. Often, this is achieved through local or regional anesthesia, administered via neural blockade. General anesthesia is induced intravenously and maintained through intravenous infusion or inhalation agents.

42. In a typical hospital, approximately 50% of procedures that take place in an operating room require either no anesthesia or only local or regional anesthesia.

43. Most hospitals, including Defendants, do not directly employ anesthesiologists. Instead, anesthesiologists are employed by medical corporations or physician groups which have agreements with hospitals to use their facilities to perform medical procedures. These physician groups bill payors using the standardized 92UB1450 form, independently of any bills submitted by the hospital. This physician billing is done pursuant to the Current Procedural Terminology ("CPT") coding system.

44. Bills generated by hospitals, including Defendants, typically follow guidelines developed by the National Uniform Billing Committee (NUBC), which periodically issues the NUBC Official UB-04 Data Specifications Manual. This manual contains a number of "revenue codes" hospitals use to charge for their services and use of their facilities. The manual is comprehensive, and covers every conceivable cost item a hospital may incur for any given procedure. Codes are three digits long, and the first two reflect a general category. For example, code 25x refers generally to "pharmacy." Within that code are specific entries, such as 250 for "general classification," or 258 for "IV solutions."

45. These physician and hospital bills are distinct – they are generated and submitted to payors independently of one another. In the Relator's experience, insurance company claim examiners do not compare the data in the forms side by side for inconsistency.

46. Hospitals, including those operated by Defendants, maintain software called chargemasters. These chargemasters define the rates at which the various NUBC revenue codes are billed by the hospital. A hospital's chargemaster rates apply equally to all patients that

access the hospital through private health insurance plans, though some payors may have contracted with the hospital for discounts on the total bills submitted.

47. Hospital services or facilities used for anesthesia are captured in a number of NUBC revenue codes. Code 25x, the pharmacy code, captures the cost of various anesthesia agents. Code 36x, the operating room code, captures the equipment and staffing costs of the operating room itself. Because code 36x covers the costs of operating room equipment and staffing, it is properly billed on a chronometric basis—that is, it is billed per unit of time. Typically, a patient is billed for the first half hour of operating use (or fraction thereof), and on fifteen minute increments thereafter.

48. The NUBC also allows use of code 96x for the professional services of an anesthesiologist or a trained anesthesiology nurse employed directly by the hospital. As noted above, however, Defendants do not employ anesthesiologists and therefore do not charge to this code. In general, the use of 96x code is vanishingly rare in the industry.

49. Finally, the 37x code for "anesthesia services" is properly used to fill a minor gap in hospital charges related to anesthesia that is not captured in other codes, including but not limited to the codes identified in the preceding paragraphs. The 37x code may be used to charge for the services of a technical assistant (*i.e.*, a non-skilled hospital employee who is neither a nurse nor a physician) to prepare an operating room for the anesthesiologist; certain anesthesia inhalation gasses not covered under the drug/pharmacy codes, including code 25x; and anesthesia-specific disposable items. Because code 37x only captures these ancillary, one-time charges, it should not be billed on a chronometric basis.

50. On those occasions when 37x charges are appropriate, the total costs which may be properly recovered through the 37x code ranges between $150 and $250 per patient.

Defendants' Misuse of the 37x Anesthesia Code

51. As noted above, numerous procedures that take place in Defendants' operating rooms require no anesthesia. Still other procedures require only local or regional anesthesia *via* injection. In such cases, there is no legitimate basis for any 37x charges. Nevertheless, based on Relator's analysis of bills submitted to payors by Sutter hospitals,

Defendants appear to charge 37x even for these cases. Similarly, a review of Sutter hospitals' bills and related patient records revealed that the 37x code was charged to patients in radiology suites when there was no indication of anesthesia being provided. These 37x charges are for services not actually rendered, and are therefore fraudulent, false and misleading under Penal Code section 550.

52. For those procedures where the 37x code may be legitimately billed, Sutter's practices and resulting charges also violate Penal Code section 550. As described above, after application of revenue codes 25x and 36x, the only remaining anesthesia-related costs incurred by Defendants are for certain anesthesia agents not captured in the pharmacy codes, some disposable supplies, and the cost of room or tray setup by an unskilled technician. These ancillary costs are captured in the 37x code, and should total approximately $150-$250.

53. However, based on Relator's research and review of bills submitted by Sutter facilities, every time one of their operating rooms is used, Defendants impose a 37x charge, on a time basis, for the entire period the patient is in the operating room. In 2005, for example, one Sutter hospital's rates (known as "chargemasters") for the 37x code were set at $1,610.55 for the first half hour (or part thereof) and $457.50 for each subsequent quarter hour (or part thereof). Comparable rates apply at all Sutter hospitals, and the rates have increased over time. As a consequence, Sutter hospitals routinely charge, on average, $3,000 to $5,000 under the 37x code, when they are entitled to no more than $150 to $250 under that code, if anything.

54. These 37x charges so far exceed actual costs that it is clear Defendants are actually double billing for costs captured in the anesthesiologist's bill or in other revenue codes, or are simply billing for services not actually provided, in violation of Penal Code section 550. Indeed, based on Relator's familiarity with anesthesia billing (its principal is a practicing clinical anesthesiologist), and on Relator's review of bills submitted by Sutter hospitals and anesthesiologists to payors, the resulting 37x charges are significantly larger than bills submitted by anesthesiologists for the same procedure. Further, based on the Relator's review of Sutter hospitals' cost reporting to the Federal government under the Medicare program, charges claimed under the 37x code dwarf the actual costs of providing anesthesia as reported to the government.

55. Sutter's use of chronometric billing under the 37x code constitutes an independent false, fraudulent, and/or misleading practice. Chronometric billing under 37x implies the patient is being billed for the time-based services of an anesthesiologist, when in fact the anesthesiologists bill separately, and any time-based services that could result in significant charges by the hospital are captured in other revenue codes, notably, the 36x operating room code.

56. The resulting overcharges also render illusory any negotiated discounts owed to insurers and other payors. For example, many insurers, HMOs, and PPOs negotiate discounts ranging between 10% and 35% off the Defendants' "regular billing rates." By inflating their bills by thousands of dollars through the 37x code, the Sutter hospitals submit claims to the insurers which in fact are not discounted, or which are discounted far less than required by the insurers' agreements. All insurers who have access to Sutter hospitals through Defendants MultiPlan and PHCS are defrauded in this manner.

57. On information and belief, the wrongdoing described herein began in 2001, if not earlier, and is ongoing. Relator first discovered the facts constituting grounds for commencing this action with respect to the billing practices of California Pacific Medical Center in September 2007, when he met with a representative of that hospital and performed an audit of certain of its billings. As described above, upon further investigation, including through review of bills submitted to payors by Sutter hospitals and physician groups and comparisons of 37x charges against Medicare cost reports, Relator concluded that the false billing practices were commonly engaged in by the Sutter Defendants.

58. Sutter Health was and is a beneficiary of these practices since the revenue and profits from the fraudulent 37x charges were upstreamed to Sutter Health and used for the benefit of the Sutter network. Further, based on the widespread nature of the fraudulent 37x charges in Sutter hospitals state-wide, Plaintiff alleges Sutter Health established, implemented, and/or ratified the policy of charging fraudulent 37x charges, rendering Sutter Health responsible for the misconduct.

The Role of MultiPlan and PHCS and Does 401-500

59. In health insurance matters, PPOs and HMOs are managed care organizations in which medical doctors, hospitals and other health care providers have promised to provide health care benefits to an insurer's or third party administrator's insureds at reduced rates. The PPOs and HMOs earn money by charging access fees to insurance companies which use their network. PPOs and HMOs typically are involved in negotiating with health care providers to set fee schedules. Health care providers often submit bills directly to the PPOs and HMOs, which review the bills and seek payment by their subscribing insurance companies. PPOs and HMOs also generally provide utilization review, wherein its representatives review records of treatment to verify the treatment and billing is appropriate for the condition treated. PPOs and HMOs also often handle disputes between insurers and providers.

60. On its website, Defendant MultiPlan describes itself as the nation's oldest and largest supplier of independent, network-based cost management solutions with more than half a million healthcare providers under contract, and 65 million claims processed through its networks each year. MultiPlan also offers fee negotiation services to its healthcare provider clients through a single electronic claim submission.

61. Defendant Private Healthcare Systems, Inc., or PHCS, was acquired by MultiPlan in October 2006, and is a subsidiary of MultiPlan.

62. MultiPlan's and PHCS's business model set the stage for the statutory violations that are alleged in this complaint. These companies have a substantial market share in California and serve as middlemen between hospitals and insurers. Specifically, insurers contract with PHCS and MultiPlan to gain access to their network of Preferred Provider Organizations (PPOs) at a discounted price from the providers' (*e.g.*, hospitals') "regular billing rates." The hospitals, through their own contracts with MultiPlan or PHCS, gain access to the subscribers of insurance companies that have contracted with MultiPlan or PHCS.

63. Upon information and belief, the terms of the Systemwide Agreements between PHCS/MultiPlan and the Sutter Defendants are binding on the health insurers, which access Sutter hospitals through operation of these Systemwide Agreements.

64. The Systemwide Agreements contain provisions which prevent healthcare insurers, referred to as "payors" in the Agreements, from challenging the reasonableness of the Sutter hospitals' bills. This is accomplished through "hospital audit policies." These policies expressly provide that questions and opinions regarding "medical necessity," "reasonableness of charges," and "the propriety of a provider's usual and customary practices," are beyond the scope of an audit and shall not be a part of any audit permitted under the agreements. Similarly, the Systemwide Agreements impose strict audit time limits and prohibitions on line-item review of bills. Such provisions are a common feature of agreements entered into between the Sutter Defendants and PPOs and HMOs, including those Defendants sued herein as Does 401-500.

65. These terms effectively preclude insurer challenges to the reasonableness of charges by the Sutter Hospitals. As such, PHCS and MultiPlan are properly described as aiding or abetting the Sutter Hospitals' fraud, in violation of Penal Code sections 550(b)(1) and (2), and Insurance Code section 1871.7.

66. Moreover, this arrangement enables the Sutter Defendants to impose exorbitant 37x charges under cover of the agreed discount payors negotiate with MultiPlan/PHCS. In fact, because overall bills are vastly inflated due to the Sutter hospitals' double-billing, or billing for services not rendered, the negotiated discounts are rendered illusory.

Fraudulent, False and Misleading Billing

67. Thus, using a sophisticated knowledge of the applicable billing and reporting provisions to insurers, and under cover of contracts that limit payors' ability to challenge the charges, the Sutter Defendants authored, created and/or approved false, fraudulent, and misleading medical reports, records, and bills to the insurance companies for payment. Sutter Defendants submitted the false and misleading writings to various insurers in support of fraudulent, false, or misleading 37x charges.

68. Plaintiffs make the following specific fraud allegations against the Sutter Defendants:

a. ***Who***: The Sutter Defendants, and their employees, officers, and agents, submitted claims for payment to various insurers that contained false, fraudulent, and

misleading charges. Without discovery, Plaintiffs are unaware of, and therefore unable to identify, the true names and identities of those individuals at the Sutter Defendants responsible for actual claim submissions or formulating the policy of submitting these illegal charges. The inflated bills are submitted to the numerous insurers, HMOs, PPOs and other health plans, including, without limitation, Aetna, American Insurance Consultants, Anthem Blue Cross of California, Blue Shield of California, California Foundation for Medical Care, Cigna, Coventry First Health, Great West Healthcare, Healthnet, Healthcare Fund of Superior California, IPM Health & Welfare Trust, Integrated Healthcare Administration, Interplan Health Group, Managed Care Incorporated, National Medical Audit, PHCS, Paracelus Healthcare Corporation, Physicians Mutual Insurance Company, Solano Partnership Healthplan, Tricare, Union Pacific Railroad Company PPO, United Healthcare, Viant and Wilson & Paschall, Inc.

b. ***What***: The Sutter Defendants knew, or were reckless in not knowing, that the charges they submitted under 37x were already captured in other revenue codes, including, for example, codes 25x and 36x, and in anesthesiologists' separate bills to payors.

c. ***When***: The Sutter Defendants have engaged in this practice of submitting 37x charges for services not rendered, or services already compensated, since approximately 2001, and on an ongoing basis continuing to this day. In that time, the Sutter Defendants have submitted hundreds of thousands of claims, each of which contains fraudulent 37x charges as described herein.

d. ***Where***: Hospitals affiliated with the Sutter Defendants prepared bills containing false 37x charges in the California counties in which the Sutter hospitals are located and submitted these charges in bills to health insurance companies, or to PPOs, HMOs, and similar third party administrators, which in turn sought payment from health insurance companies.

e. ***How:*** The Sutter Defendants impose the fraudulent 37x charges by billing for "anesthesia services" on a time-basis for the entirety of a patient's stay in an operating room. This practice misleadingly implies the 37x charge captures the services of trained

professionals or operation of capital equipment, even though all such charges are already captured in other revenue codes, such as 25x and 36x, and in anesthesiologists' separate bills to payors.

f. ***Why***: The Sutter Defendants engage in this practice in order to increase revenues per patient and thereby increase their profits.

69. Plaintiffs make the following specific fraud allegations against Defendants MultiPlan and PHCS:

a. ***Who***: MultiPlan and PHCS, and their employees, officers, and agents, entered into and oversaw contracts which limited payors' audit rights against the Sutter Defendants' fraudulent charges, and otherwise discouraged meaningful review of such charges. Without discovery, Plaintiffs are unaware of, and therefore unable to identify, the true names and identities of those individuals at MultiPlan and PHCS responsible for this conduct.

b. ***What***: MultiPlan and PHCS knew, or were reckless in not knowing, that the Sutter Defendants' 37x charges were fraudulent, false or misleading, that their contracts with the Sutter Defendants precluded meaningful review of these improper charges, and that bills inflated due to the fraudulent 37x charges rendered illusory any discounts payors' were entitled to under their contracts with MultiPlan and PHCS.

c. ***When***: MultiPlan and PHCS engaged in this practice of aiding and abetting the Sutter Defendants' 37x charges for services not rendered, or services already compensated, since approximately 2001, and on an ongoing basis continuing to this day. In that time, the Sutter Defendants have submitted hundreds of thousands of claims pursuant to contracts with MultiPlan and PHCS, each of which contains fraudulent 37x charges as described herein.

d. ***Where***: MultiPlan and PHCS engaged in this conduct at their respective principal places of business and other places of business throughout California and the United States.

e. ***How***: MultiPlan and PHCS carried out this misconduct, and aided and abetted the Sutter Defendants' misconduct, through their acceptance of bills by hospitals operated by the Sutter Defendants despite knowledge or reckless disregard of false 37x charges; oversight of contracts which limited payors' audit rights against the Sutter Defendants' fraudulent

charges, including during audit review procedures; refusal to challenge the false 37x billings submitted by the Sutter hospitals; and practice of otherwise discouraging meaningful review of such charges.

f. ***Why***: MultiPlan and PHCS engage in this practice in order to gain access to Sutter Defendants' facilities, which in turn draws insurers to do business with them and ultimately increases their market share and profits, as Multiplan gets paid a percentage of the purported discount it provides to the insurers.

70. The contracts between Multiplan/PHCS and the Sutter hospitals contains provisions which both Sutter and Multiplan/PHCS contend prevent any health insurer from refusing to pay any particular line item charged, even if the charge is fraudulent. Multiplan/PHCS uses that provision to discourage payors from examining the legitimacy of the bills the Sutter hospitals submit. Multiplan/PHCS and the Sutter hospitals use the contractual provision to discourage insurers from examining bills. Because Defendants use the contractual provision to prevent insurers from refusing to pay for fraudulent billing entries, the provision encourages and abets fraudulent activity and is against the public policy of the State of California.

CAUSES OF ACTION

FIRST CAUSE OF ACTION

California Insurance Frauds Prevention Act, Ins. Code Section 1871.7

Against the Sutter Defendants and DOES 1 through 400

71. Plaintiffs incorporate by reference and reallege the preceding paragraphs.

72. This is a claim for damages and penalties under the Insurance Frauds Prevention Act, codified at Cal. Ins. Code section 1871.7, brought by the State of California.

73. Penal Code section 550(a) makes it illegal to:

(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance.

(2) Knowingly present multiple claims for the same loss or injury, including presentation of multiple claims to more than one insurer, with an intent to defraud.

(3) Knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim.

(4) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit.

(5) Knowingly submit a claim for a health care benefit that was not used by, or on behalf of, the claimant.

74. Insurance Code section 1871.7(b) provides that every person who violates Penal Code section 550 is subject to civil penalties of between $5,000 and $10,000, plus an assessment of not more than three times the amount of each claim for compensation.

75. By virtue of the acts described above, the Sutter Defendants violated Penal Code section 550 and, in turn, Ins. Code section 1871.7.

76. The Sutter Defendants submitted false, fraudulent or misleading bills to payors by automatically charging all operating room patients for 37x anesthesia services on a time-basis, even where the procedure did not require general anesthesia.

77. The Sutter Defendants submitted false, fraudulent, or misleading bills to payors by charging for anesthesia services under 37x that are already captured in other revenue codes or in anesthesiologists' separate bills.

78. The Sutter Defendants submitted false, fraudulent, or misleading bills to payors through use of time-based or chronometric billing of 37x charges. Time-based 37x charges imply the patient is being billed for time-based professional or operating room services, when in fact all such services are captured in other codes or in the anesthesiologists' separate bill.

79. The Sutter Defendants submitted false, fraudulent or misleading bills to payors by inflating the bills through unjustified 37x charges, thereby rendering illusory any discounts the insurers negotiated with the Sutter Defendants, either on their own or through a third party such as Defendants PHCS and MultiPlan.

80. As a result of the above-described conduct, Plaintiff is entitled to damages as provided for by Insurance Code section 1871.7.

SECOND CAUSE OF ACTION

California Insurance Frauds Prevention Act, Cal. Ins. Code section 1871.7

Against MultiPlan, PHCS and DOES 401 through 500

81. Plaintiffs incorporate by reference and reallege the preceding paragraphs.

82. This is a claim for damages and penalties under the Insurance Frauds Prevention Act, codified at Cal. Ins. Code section 1871.7, *et seq.*, brought by the State of California.

83. Penal Code section 550(b) makes it illegal to "knowingly assist or conspire with any person" to do any of the following:

(1) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

84. By virtue of the acts described above, Defendants MultiPlan and PHCS are co-conspirators and aiders and abettors of the Sutter Defendants' violations of Penal Code section 550 and Ins. Code section 1871.7. Moreover, by their participation in similar conduct, Does 401-500 are likewise co-conspirators and aiders and abettors in violations of Penal Code section 550 and Ins. Code section 1871.7.

85. MultiPlan's and PHCS's contracts with the Sutter Defendants establish restricted audit policies that effectively preclude audits by health insurers regarding medical necessity, reasonableness of charges, and the propriety of a provider's usual and customary practices, thereby aiding and abetting the Sutter Defendants' fraudulent, false and misleading 37x billing.

86. MultiPlan's and PHCS's practice of aiding and abetting the Sutter Defendants' misconduct renders illusory any negotiated discounts, which are minimized or effectively eliminated by the fraudulent 37x charges.

87. As such, PHCS and MultiPlan are properly described as aiding or abetting the Sutter Defendants' fraud, in violation of Penal Code section 550, and Insurance Code section 1871.7.

THIRD CAUSE OF ACTION

Declaratory and Injunctive Relief, Ins. Code Sections 1871.7(b)

88. Plaintiffs incorporate by reference and reallege the preceding paragraphs.

89. Insurance Code Section 1871.7(b) empowers the Court "to grant other equitable relief, including temporary injunctive relief, as is necessary to prevent the transfer, concealment, or dissipation of illegal proceeds, or to protect the public."

90. The Commissioner seeks equitable relief pursuant to Ins. Code section 1871.7(b), because unless equitable relief is granted, Defendants are likely to continue their unlawful conduct after the conclusion of this litigation. The State of California will continue to suffer damage if Defendants continue their fraudulent activities, as health insurance rates will continue to increase more than they otherwise would or should.

91. As described above, Defendants use contractual provisions to prevent challenges to fraudulent billings. These contractual provisions are contrary to the Insurance Code and public policy, and should therefore be declared unenforceable pursuant to Civil Code section 1667.

PRAYER

WHEREFORE, the State of California prays for judgment against Defendants as follows:

a. Judgment in an amount equal to three times the amount of each claim for compensation by the Defendants;

b. A civil penalty of $10,000 for each violation of Insurance Code section 1871.7 or Penal Code section 550;

c. Disgorgement of profits unlawfully acquired by Defendants;

d. An award to Relator of the maximum amount allowed pursuant to Insurance Code section 1871.7;

e. Attorneys' fees, expenses and costs of suit herein incurred, pursuant to Insurance Code section 1871.7;

f. An injunction against each of the defendants for any continuing conduct violating Penal Code section 550;

g. An order directing Defendants to cease and desist from violating California Insurance Code section 1871.7 and California Penal Code section 550;

h. An order and findings declaring that the contractual provisions used by Defendants to prevent challenges to fraudulent billings are against the public policy of the State of California and therefore unenforceable.

i. Such other and further relief as the Court deems just and proper.

Respectfully submitted,

Dated: 4-11-11

By: _____
Gene S. Woo

GENE S. WOO
Senior Staff Counsel, California
Department of Insurance
Attorneys for Intervenor, DAVE JONES,
as California Insurance Commissioner

Dated: 4-11-11

By: _____
Robert J. Nelson

William Bernstein, State Bar No. 065200
Robert J. Nelson, State Bar No. 132797
Nimish R. Desai, State Bar No. 244953
LIEFF, CABRASER, HEIMANN & BERNSTEIN, LLP
275 Battery Street, 29th Floor
San Francisco, CA 94111-3339
Telephone: (415) 956-1000
Facsimile: (415) 956-1008

William D. Hughes, State Bar No. 60370
E. Kenneth Purviance, State Bar No. 126206
HUGHES & NUNN LLP
350 10th Ave., Suite 960
San Diego, CA 92101
Telephone (619) 231-1661
Facsimile (619) 236-9271

Attorneys for Relator